DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 97-014

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10-1-97

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396r-4; 42 CFR 447

7. FEDERAL BUDGET IMPACT: *
a. FFY 98 $ 10,000
b. FFY 99 $ 10,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Acute Hospital Inpatient Payment System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 31, 1997

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-31-97

18. DATE APPROVED: JUN 30 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1997

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis M. Maloney for

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
RONALD PRESTON
Associate Regional Administrator, DMSO

23. REMARKS:

OFFICIAL
JUN 30 2001

DEC 31 97
BOSTON-HCFA-DMAD
RECEIVED

HCFA-179 (07-92) *Instructions on Back*

*Projected marginal impact expressed in thousands

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

I: OVERVIEW

On August 6, 1996, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the MassHealth program's sixth Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as MassHealth providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing MassHealth recipients with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; and (4) currently utilize more than fifty (50%) of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA. All eligible acute hospitals are participating providers.

The RFA was amended effective October 1, 1997 to incorporate the following updates and adjustments:

- A rate update of 2.14% was applied to the statewide average payment amount per discharge, observation and ED add-ons to the inpatient per discharge amount, and the administrative day rates;
- The inpatient casemix adjustment was updated to reflect audited paid claims from the period of 6/1/96-5/31/97;
- The wage area adjustment was updated to reflect the most recent HCFA wage index information;
- Pass-through and direct medical education amounts were rebased to 1996;
- A technical refinement was made to the methodology for calculating inpatient pass-through and direct medical education amounts. The refinement allows the costs associated with discrete non-acute units to be treated more consistently with the reporting requirements of the DHCFP-403.

II: DEFINITIONS

A) Administrative Day (AD) - A day of inpatient hospitalization on which a recipient's care needs can be provided in a setting other than an acute inpatient hospital, and on which the recipient is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416 attached as Exhibit 1.

B) Administrative Day Per Diem - An all-inclusive per diem payable to hospitals for administrative days.

C) Clinical Laboratory Service - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

D) Community-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

E) Contract (Hospital Contract or Agreement) - The agreement executed between each selected hospital and the Division, which incorporates all of the provisions of the RFA.

F) Contractor - Each hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

G) Distinct Part Psychiatric Unit (DPU) - An acute hospital's psychiatric unit that meets all requirements of 42 C.F.R. Part 412.

H) Division - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

I) Division of Health Care Finance and Policy (DHCFP) - a Division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services created pursuant to G.L. c.118G. DHCHP performs many of the functions performed by the former Rate Setting Commission and former Division of Medical Security.

J) Gross Patient Service Revenue - The total dollar amount of a hospital's charges for services rendered in a fiscal year.

K) Health Maintenance Organization (HMO) - An entity with which the Division contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance to operate under M.G.L. c. 176G, or that otherwise meets the State Plan definition of an HMO.

L) Hospital - Any hospital licensed under M.G.L. c. 111, §51 (and the teaching hospital of the University of Massachusetts Medical School), and which meets the eligibility criteria set forth in Section I.

M) Hospital-Based Entity - Any entity which contracts with a hospital to provide medical services to recipients, on the same site as the hospital's inpatient facility.

N) Hospital-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide services to recipients, on the same site as the hospital's inpatient facility. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, and physician assistants are not hospital-based physicians.

O) Hospital-Specific Standard Payment Amount per Discharge (SPAD) - An all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete reimbursement for an acute episode of illness, excluding the additional payment of Outliers, Transfer per Diems, and Administratively Necessary Days.

P) Inpatient Services - Services reimbursable by the Division pursuant to the RFA which are provided to recipients admitted as patients to an acute unit in a hospital.

Q) Managed Care Organization (MCO) - The Managed Care Organization with whom the Division contracts to administer the Division's Mental Health and Substance Abuse Program (MH/SAP)

R) Medicaid (also referred to as MassHealth) - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E and Title XIX of the Social Security Act, and the Waiver.

S) Mental Health/ Substance Abuse Program (MH/SAP) - A managed care program for the provision of mental health and substance abuse services to Medicaid recipients enrolled in the program.

T) Outlier Day - Each day during which a recipient remains hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of hospitalization are not counted toward the outlier threshold as described in Section IV.B.8.

FF) Pass-Through Costs - Organ acquisition and malpractice costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount.

HH) Pediatric Specialty Hospital - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

II) Pediatric Specialty Unit - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.

KK) Primary Care Clinician Program (PCCP) - A comprehensive managed care program with primary care clinicians managing enrolled recipients' medical care.

LL) Public Service Hospital - Any public acute hospital or any acute hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 (see attached Exhibit 2) which has a private sector payer mix that constitutes less than twenty five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.

NN) Rate Year (RY) - The period beginning October 1 and ending September 30. RY98 begins on October 1, 1997 and ends on September 30, 1998.

OO) Recipient (also referred to as member) - A person determined by the Division to be eligible for medical assistance under the MassHealth program.

RR) Sole Community Hospital - Any acute hospital classified as a sole community hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any hospital which demonstrates to the Division of Health Care Finance and Policy's satisfaction, that it is located more than 25 miles from other acute hospitals in the Commonwealth and which provides services for at least sixty percent if their primary service area.

SS) Specialty Hospital - Any acute hospital which limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer and which qualifies as exempt from the Medicare prospective payment system regulations.

TT) Transfer Patient - Any patient who meets any of the following criteria: 1) transferred between acute hospitals; 2) transferred between a distinct part psychiatric unit and a medical / surgical unit in an acute hospital; 3) receiving substance abuse or mental health-related services whose assignment in the MH / SAP changes; or 4) who becomes eligible for Medicaid after the date of admission and prior to the date of discharge.

VV) Upper Limit - The term referring to the level below which it is determined that the hospital reimbursement methodology will result in payments for hospital services in the aggregate that are no more than the amount that would be paid under Medicare principles of reimbursement.

XX) Usual and Customary Charges - Routine fees that hospitals charge for acute inpatient and outpatient services rendered to patients regardless of payer source.

XX) Waiver - the Section 1115 Medicaid Research and Demonstration Waiver approved by the U.S. Department of Health and Human Services on April 24, 1995, and authorized by Chapter 203 of the Massachusetts Acts and Resolves of 1996.

III. NON-COVERED SERVICES

The Division will reimburse MassHealth participating hospitals at the rates established in the RFA and accompanying contract for all acute inpatient services provided to MassHealth recipients except for the following:

A. Mental Health and Substance Abuse Services for Recipients Assigned to the MH/SAP

The MCO contracts with a provider network to deliver mental health and substance abuse services for MassHealth recipients assigned to the MH/SAP. Hospitals in the MCO's network are paid by the MCO for services to recipients assigned to the MH/SAP, pursuant to the contract between the MCO and the hospital.

Hospitals that are not in the network (hereinafter "Non-Network Hospitals") do not qualify for Medicaid reimbursement for recipients assigned to the MH/SAP seeking mental health or substance abuse non-Emergent Care, except in accordance with a service specific agreement with the MCO.

Non-Network Hospitals that provide medically necessary mental health and substance abuse Emergent Care to MH/SAP assigned recipients qualify for reimbursement by the MCO. Hospitals are not entitled to any reimbursement from the Division, and may not claim such reimbursement for any services which are reimbursed by the MCO.

B. HMO Services

Hospitals providing services to MassHealth recipients enrolled in HMOs will be reimbursed by HMOs for those services.

Hospitals may not bill the Division, and the Division will not reimburse hospitals for services provided to MassHealth recipients enrolled in an HMO where such services are covered by the HMO's contract with the Division. Furthermore, hospitals may not "balance bill" the Division for any services covered by the HMO's contract with the Division. HMO reimbursement shall be considered payment in full for any HMO-covered services provided to MassHealth recipients enrolled in an HMO.

C. **Air Ambulance Services**

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

D. **Hospital Services Reimbursed through Other Contracts or Regulations**

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and / or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made pursuant to the contract and / or regulations governing the special program initiative, and not through the RFA and resulting contract.

E. **Non-Acute Units in Acute Hospitals**

The Division shall not reimburse acute hospitals through the RFA for services provided to recipients in non-acute units within acute hospitals.

IV: REIMBURSEMENT SYSTEM

A. DATA SOURCES

In the development of each hospital's RY98 standard payment amount per discharge (SPAD), the Division used Medicaid audited paid claims for the period June 1, 1996 to May 31, 1997; the FY96 RSC-403 report, as submitted to the Rate Setting Commission n/k/a DHCFP; and the RY96 Merged Casemix/ Billing Tapes, as accepted by the Rate Setting Commission, as the primary sources of data to develop base operating costs. The wage area adjustment was derived from the 1994 Medicare 2552 Cost Report.

B. METHODOLOGY FOR INPATIENT SERVICES

1. Overview

Payments for inpatient services, other than for psychiatric services provided in distinct part psychiatric units, will consist of the sum of 1) a statewide average payment amount per discharge that is adjusted for wage area differences and the hospital-specific Medicaid casemix; 2) a per discharge, hospital-specific payment amount for hospital-specific expenses for malpractice and organ acquisition costs; 3) a per discharge, hospital-specific payment amount for direct medical education costs which includes a primary care training incentive and a specialty care reduction; and 4) a per discharge, hospital-specific payment amount for the capital cost allowance, adjusted by hospital-specific casemix. Each of these elements is described in Sections IV.B.2 through IV.B.5. The statewide average payment amount per discharge incorporates an efficiency standard.

Payment for psychiatric services provided in distinct part psychiatric units to MassHealth patients who are not served either through a contract between the Division and its MH/SAP MCO or an HMO shall be made through an all-inclusive regional weighted average per diem, updated for inflation and adjusted to reflect any reductions negotiated by the hospital and the Division's MH/SAP MCO (described in Section IV.B.7).

Payment for physician services rendered by hospital-based physicians will be made as described in Section IV.B.10.

2. **Hospital-Specific Standard Payment Amount Per Discharge (SPAD)**

a. Calculation

The RY98 statewide average payment amount per discharge is based on the actual statewide costs of providing inpatient services in FY95 updated as described below. The average cost per discharge for FY95 was determined using the FY95 DHCFP Merged Billing and Discharge Data and the FY95 RSC-403, as screened and updated as of June 20, 1996. Cost and utilization data for the following were excluded in calculation of the statewide average payment amount per discharge; hospitals and hospital units with unique circumstances, as set forth in Sections IV.C.1-IV.C.3; and psychiatric units.

The average cost per discharge in each hospital was derived by dividing total hospital costs by total hospital discharges, excluding those from psychiatric, chronic or observation units, or skilled nursing facilities. Costs associated with distinct part psychiatric units, chronic units, SNF units, and observation units were excluded. The cost centers which are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical staff expenses were included.

Malpractice, organ acquisition, capital, and direct medical education costs were excluded from the calculation of the statewide average payment amount.

The average cost per discharge for each hospital was then divided by the hospital's Massachusetts-specific wage area index and by the hospital-specific FY95 all-payer casemix index using the Version 12.0 New York grouper and New York weights. (For the non-exempt Massachusetts hospitals in the areas designated by the Geographical Classification Review Board of the Health Care Financing Administration, effective September 1, 1995, the average hourly wage of each area was calculated from audited FY93 Medicare 2552 Cost Reports. Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the

Springfield area index, the Baystate Medical Center's wages and hours were included). This step results in the calculation of the standardized Medicaid costs per discharge for each hospital. These standardized costs per discharge were compared to the standardized Medicaid costs per discharge from the RY96 RFAwith three years of inflation. If the RY96 standardized Medicaid cost per discharge was at least 15% more than the standardized cost per discharge calculated in RY97, the standardized costs per discharge were capped at 15% over the RY96 Medicaid costs per discharge.

The hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of Medicaid discharges for the hospitals was produced; and an efficiency standard was established as the weighted median cost per discharge. The efficiency standard was established as the cost per discharge corresponding to the discharge located at the seventy-fifth percentile; this means that 75% of the Medicaid caseload was treated in hospitals whose operating costs were recognized in full. The weighted seventy-fifth percentile plus an update factor of 2.14% is the highest standardized cost per discharge that will be recognized for any individual hospital in the computation of the statewide average payment amount. The RY98 efficiency standard of $2,975.09 equals the RY97 efficiency standard updated by 2.14% to reflect price changes between RY97 and RY98.

The statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-five percent (95%); by c) an inflation factor of 3.16% which reflects price change between RY95 and RY96; by d) an inflation factor of 2.38% which reflects price changes between RY96 and RY97; and by an inflation factor of 2.14% which reflect price changes between RY97 and RY98. Each inflation factor is a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the HCFA market basket to reflect conditions in the Massachusetts economy. The resulting statewide average payment amount per discharge is $2,691.00.

The statewide average payment amount per discharge was then multiplied by the hospital's Medicaid casemix index (using version 12.0 of the New York Grouper and New York weights) for the period June 1, 1996 through May 31, 1997, and the hospital's Massachusetts specific wage area index to derive the hospital-specific standard payment amount per discharge (SPAD). The wage area indexes were derived from audited FY94 Medicare Cost Reports (2552).

The outlier adjustment is used for the payment of outlier days as described in Section IV.B.8.

When groupers are changes and modernized, it is necessary to adjust base payment rates so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that the Division is following, and one that has been a feature of the Medicare DRG program since its inception. The Division reserves the right to update to the new grouper should there be a grouper developed during the rate year.

b. **SPAD Add-On for Emergency Department Services**

A additional amount is added to every hospital's per discharge payment rate to account for routine Emergency Department services that result in an inpatient admission. This amount was calculated as follows. The average Medicaid rate of payment for emergency visits for all hospitals in RY95 was multiplied by the percentage of inpatient admissions for all hospitals in RY95 that were admitted through the Emergency Department. This rate was then multiplied by an inflation factor of 3.16% to reflect price changes between RY95 and RY96, by an inflation factor of 2.38% to reflect price changes between RY96 and RY97, and by an inflation factor of 2.14% to reflect price changes between RY97 and RY98. The amount of the add-on is $26.96.

c. **SPAD Add-On for Observation Services**

An additional amount is added to every hospital's per discharge payment rate to account for routine observation services which result in an inpatient admission. This amount was calculated as follows. The average Medicaid rate of payment for observation services for all hospitals in RY95 was multiplied by the percentage of inpatient admissions for all hospitals in RY95 that were admitted from an observation bed. This rate was then multiplied by an inflation factor of 3.16% to reflect price changes between RY95 and RY96, by an inflation factor of 2.38% to reflect price changes between RY96 and RY97, and by an inflation factor of 2.14% to reflect price changes between RY97 and RY98. The amount of the add-on for RY98 is $11.87.

3. Calculation of the Pass-through Amount per Discharge

The inpatient portion of malpractice costs was derived from each hospital's FY96 DHCFP 403 report as screened and updated as of July 2, 1997. The pass-through amount per discharge is the sum of the per discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the hospital's inpatient portion of expenses by the number of total, all-payer days and then multiplying the cost per diem by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division used the Medicaid audited paid claims file for date of payment for the period June 1, 1996 through May 31, 1997 to develop casemix data.

The pass-through amount per discharge is the product of the per diem costs of inpatient malpractice and organ acquisition costs and the hospital-specific Medicaid average length of stay from casemix data, excluding such costs related to services in Distinct Part Psychiatric Units and services in non-acute units. The per diem malpractice cost is net of malpractice costs associated with services in Distinct Part Psychiatric Units and services in non-acute units. The days used in the denominator are also net of days associated with such units.

4. Direct Medical Education

The inpatient portion of direct medical education costs was derived from each hospital's FY96 DHCFP 403 report as screened and updated as of July 2, 1997. For hospitals which began new primary care physician training programs between October 1, 1994 and July 1, 1995, the Division shall recognize such new costs submitted by the hospital, as are determined to be reasonable by the Division, to be revised using costs which shall be based on costs reported in the FY96 DHCFP 403 Report as screened and updated as of July 2, 1997. Such incremental costs for new programs shall be annualized. For all hospitals, the direct medical education amount per discharge is the product of the per diem costs of inpatient direct medical education and the hospital-specific Medicaid average length of stay from casemix data, excluding such costs related to services in Distinct Part Psychiatric Units and services in non-acute units. The per diem direct medical education costs are net of direct medical education costs associated with services in Distinct Part Psychiatric Units and services in non-acute units. The days

used in the denominator are also net of days associated with such units. The direct medical education per discharge amount was calculated by dividing the hospital's inpatient portion of expenses by the number of total inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division used the Medicaid paid claims file for dates of payment for the period June 1, 1996 through May 31, 1997 to develop the RY98 casemix index.

The Division has incorporated an incentive in favor of primary care training which was factored into the recognized direct medical education costs by weighting costs in favor of primary care training. An incentive of 33% of the costs was added to the per discharge cost of primary care training; a reduction of 20% of the costs was subtracted from the per discharge cost of specialty care training. The number of primary care and specialty care trainees was derived from data provided to the Division by the hospitals.

Growth in direct medical education costs attributable to wage inflation are subjected to a 5% annual limit. An audit may be performed by the Division to verify the appropriateness of reported teaching costs.

5. Capital Payment Amount per Discharge

Following a five-year phase-in, the capital payment is a casemix-adjusted capital cost limit, based on the FY91 Medicare Cost Report (2552), updated for inflation.

For each hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, and long-term and short-term interest. Total capital costs are allocated to inpatient services through the square footage-based allocation formula used in the Medicare cost report (2552). The Medicare cost report is also used to identify capital allocated to distinct part psychiatric units and to subtract this amount from total inpatient capital in order to calculate the non-DPU capital cost per discharge.

The capital cost per discharge is calculated by dividing total inpatient capital costs (less that allocated to psychiatric DPU) by the hospital's total non-DPU days, and then multiplying by the hospital-specific non-DPU Medicaid average length of stay from casemix data.

The casemix-adjusted capital efficiency standard is determined by a) dividing each hospital's FY91 capital cost per discharge by its FY91 casemix index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. The casemix-adjusted capital efficiency standard is established at the cost per discharge corresponding to the median discharge.

The capital efficiency standard was updated for inflation between RY93 and RY94 by a factor of 3.01%; for inflation between RY94 and RY95 by a factor of 2.80%; for inflation between RY95 and RY96 by a factor of 1.80%; for inflation between RY96 and RY97 by a factor of 1.00%; and by 0% for inflation between RY97 and RY98. The capital update factor is taken from annual HCFA regulations used by HCFA to update the capital payments made by Medicare. The capital update factor is computed annually by HCFA and is calculated as follows: HCFA estimates of inflation in depreciation, interest, and other capital related expenses, are multiplied by their respective weights, and summed. The casemix-adjusted capital efficiency standard per discharge is $316.42.

6. **Maternity and Newborn Rates**

Maternity cases in which delivery occurs will continue to be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for all services (except physician services) provided in conjunction with such a maternity stay including, but not limited to, follow-up home visits provided as incentives for short delivery stays, are included in the SPAD amount. There will be no additional payments to the hospital or other entities (i.e. VNA's, home health agencies) for providing these services in collaboration with the hospital. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payor.

7. **Payment for Psychiatric Services in Distinct Part Psychiatric Units**

Services provided to non-managed care MassHealth patients in distinct part psychiatric units shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which services are provided to Medicaid recipients assigned to MH/SAP.

The regions used to develop the all-inclusive regional weighted average per diem rates correspond to the six Health Services Areas established by the Massachusetts Department of Public Health (PL 93-641). These regional weighted average per diems were calculated by a) dividing each hospital's per discharge psychiatric rate established in the FY92 Medicaid RFA by the FY90 average length of stay pertaining to Medicaid psychiatric patients; b) multiplying the result for each hospital by the ratio of the hospital's Medicaid mental health days to the total Medicaid mental health days for the hospital's region; and c) summing the results for each region. The regional weighted average per diems were updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; 3.16% to reflect price changes between RY95 and RY96; 2.38% to reflect price changes between RY96 and RY97; and 2.14% to reflect price changes between RY97 and RY98.

For hospitals which are part of the Division's MCO network, the lower of the MCO's negotiated rate or the psychiatric per diem shall be the rate of payment in all cases where the psychiatric per diem established in the RFA applies.

8. Outlier Payments

Eligibility

A hospital qualifies for an outlier per diem payment in addition to the standard payment amount if all of the following conditions are met:

- o the length of stay for the hospitalization exceeds twenty (20) cumulative acute days (not including days in a distinct part psychiatric unit);
- o the hospital continues to fulfill its discharge planning duties;
- o the patient continues to need acute level care and is therefore not on administrative day status on any day for which an outlier payment is claimed;

- o the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed; and

- o the patient is not a patient in a non-acute unit within an acute hospital.

To derive the RY98 standard payment amount per day, the statewide average payment amount per discharge of $2,691.00 is divided by the average FY95 all-payer length of stay of 5.0931 days which equals $528.36. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid average length of stay from casemix data.

The outlier per diem payment amount is equal to fifty-five percent (55%) of the statewide average payment amount per day multiplied by the hospital's wage area index and casemix index, plus a per diem payment for the hospital's pass-through costs, direct medical education and capital payment amounts.

9. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one acute hospital to another will be made on a transfer per diem basis (capped at the per discharge payment) for the hospital that is transferring the patient. The amount of the transfer per diem payment is equal to the RY98 statewide average payment amount per day, multiplied by the transferring hospital's RY98 Medicaid casemix index and wage area index, plus pass-through, direct medical education and capital per diem payments.

To derive the standard payment amount per day for transfer patients, the RY98 statewide average payment amount per discharge of $2,691.00 is divided by the FY95 average all-payer Medicaid length of stay of 5.0931 days which equals $528.36. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay from casemix data.

In general, the hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in Sections IV.B.2-5, if the patient is discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital will be paid at the hospital-specific transfer per diem rate, capped at the hospital-specific per discharge amount. Additionally, "back transferring" hospitals will be eligible for outlier payments specified in Section IV.B.8.

Refer to matrices attached as **Exhibit 3** for a review of transfer scenarios and corresponding payment mechanisms involving MH/SAP-eligible and MH/SAP-ineligible recipients in MH/SAP MCO's network and non-network hospitals.

b. Transfers within a Hospital

In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be reimbursed on a per diem basis. This section shall outline reimbursement under some specific transfer circumstances. For a complete review of reimbursement under transferring circumstances involving MH/SAP-eligible recipients and MH/SAP-ineligible recipients in the MH/SAP MCO network and non-network hospitals, refer to the matrices attached as **Exhibit 3.**

(1) Transfer to\from a Chronic or Rehabilitation Unit within the Same Hospital

If a patient is transferred from an acute bed to a chronic or rehabilitation unit in the same hospital, the transfer is considered a discharge. The Division will pay the hospital-specific SPAD for the portion of the stay before the patient is transferred to the chronic or rehabilitation unit.

(2) Medicaid Payments for Newly Eligible Recipients or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible or other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay will be paid at the transfer per diem rate, up to the hospital-specific SPAD, or, if the patient is at the administrative day level of care, at the AD per diem rate.